

Group Information Sheet

Full Legal Name _____
 Contact Name _____
 Phone _____ Fax _____ Email _____
 Address _____
 City _____ State _____ Zip _____
 Company Tax ID# _____ Effective Date of Proposed Plan _____

Type of Business (with SIC code, if known) _____
 Years in Business _____

Total Number of Employees _____
 # Part-time Employees _____ Enter number using minus (1)
 # Employees in Waiting Period _____ Enter number using minus (1)
 # Employees waiving coverage (with no other coverage) _____ Enter number using minus (1)
 # Employees with other coverage _____ Enter number using minus (1)
 # COBRA Participants (if applicable) _____ Enter number using minus (1)
 COBRA Participant's Effective Date(s) (if applicable) _____
 (use space to the right, if necessary)
 # Enrolling Employees _____

Current Health Insurance Carrier (if applicable) _____
 Years with current carrier _____
 Waiting Period _____
 # Hours worked to be eligible _____
 Do you have Workers Comp? _____
 % Employer Contribution for Health Premiums:
 Employee _____ % (Minimum is 50%)
 Dependent _____ % (No minimum)

Current Benefits (if applicable):
 Type of plan (HMO, PPO, POS) _____
 Office Visit Copay _____
 Hospital Copay _____
 Prescription Copay _____
 Deductibles (if applicable) _____

Current Monthly Premium Rates (if applicable)

	Existing Rates	Renewal Rates (if available)
Employee Only		
Employee + Spouse		
Employee + Child(ren)		
Employee + 1		
Family		

Did the group on at least 50% of its working days during either of the two preceding years, employ no less than two and no more than fifty (50) Eligible employees? _____

Did the group employ 51 or more eligible employees during 50% of the working days during either of the preceding 2 calendar years? _____